Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PHYSICIANS SURGICAL CENTER

Respondent Name
BERKSHIRE HATHAWAY HOMESTATE INSURANCE CO

MFDR Tracking Number
M4-11-1144-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
DECEMBER 3, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier has been in receipt of claim for over 60-days and has not responded with payment or denial. Carrier is in direct violation of division guidelines."

Amount in Dispute: $645.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 27, 2010	Ambulatory Surgical Care Services CPT Code 62311	$645.03	$644.98

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. Neither party to this dispute submitted any explanation of benefits for the disputed services.

Issues

Is the requestor entitled to additional reimbursement?

Findings

28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

28 Texas Administrative Code §134.402(f)(1(A) states “The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply:
(1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.”

To determine the maximum allowable reimbursement (MAR) the Division gathered the following factors to be used in the calculations:

According to Addendum AA, CPT code 62311 is a non-device intensive procedure.

The 2010 Medicare conversion factor is $41.873.

The City Wage Index for Fort Worth, Texas is 0.9499.

The fully implemented ASC relative payment weight for code 62311 CY 2010 is 6.7235.

To determine the geographically adjusted Medicare ASC reimbursement for code 62311:

The Medicare fully implemented ASC reimbursement rate is found by multiplying the 2010 Medicare conversion factor by the fully implemented ASC relative payment weight = $281.53.
The Medicare fully implemented ASC reimbursement rate is divided by 2 = $140.76

This number multiplied by the City Wage Index is $133.70.

Add these two together = $274.46.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%:

$274.46 X 235% = $644.98. The respondent paid $0.00. The difference between the MAR and amount paid is $644.98; this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $644.98.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $644.98 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/03/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.